Arizona Dept. of Health Services
Division of Behavioral Health Services

Encounter Tidbits

Arizona Department of Health Services

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HIPAA Corner. . . .

Enrolled Persons' Rights Related to Protected Health Information

Right to Access Protected Health Information: Enrolled persons have the right to access and obtain a copy of their Protected Health Information or any other information in the designated record set. Please see Appendix D: ADHS/DBHS Designated Record Set for a listing of the data elements and valid values constituting the ADHS/DBHS record set. The form to be used to request access to the record set content is located in Appendix C: Request to Access Protected Health Information.

Denial of Access with a right of review: Access to Protected Health Information and any information in the designated record set may be denied, though denial is subject to review where:

a. Access is determined by a licensed professional to be likely to endanger life or physical safety of the enrolled person or another person; and such determination is documented,
b. The protected behavioral health care information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access is reasonably likely to cause substantial harm to such other person;
c. A Personal Representative requests access and a licensed professional determines that such access is reasonably likely to cause substantial harm to the enrolled person or another person.

Denial of Access without a right of review: Access to Protected Health Information and any information in the designated record set may be denied when:

a. Information was compiled in anticipation of litigation;
b. Information was collected in the course of research that includes treatment of the enrolled person and the enrolled person agreed to a suspension of the right of access during the research period;
c. In accordance with the Clinical Laboratory Improvements Amendments of 1988 (CLIA) or the Privacy Act (5 USC 552a), when applicable

Right of Review: If the basis for denial of access gives a right of review, the enrolled person has a right to have the denial reviewed by another licensed professional who did not participate in the original denial decision. Such review must be completed within a reasonable period of time, and the ADHS/DBHS must promptly:

a. Provide the enrolled person with notice of the reviewer's decision, and
b. Comply with the determination to provide or deny access.

To request a review of the denial of access to Protected Health Information, please see the Request for Review of Denial of Request for Access to Protected Health Information Notice located in Appendix C. ADHS/DBHS will respond in writing to the review request using the Notice of Outcome for Denial of Access Review form located in Appendix C.

Important Reminders . . .

Data Validation Study Contract Year 01/02

The Data Validation Study CY 01/02 record collection process has ended. All of the RBHAs have reached and surpassed the mandatory 95% of records requests submitted. Thank you to everyone that put forth such a tremendous effort to make sure your providers submitted their records timely. We will keep you informed as the Data Validation Study continues.

2002/2003 AHCCCS Pended Encounter Deletions (Void & Subvention Data)

Reminder: RBHAs need to research their 2002/2003 AHCCCS pend deletion data to determine if a CIS void needs to be submitted and review encounters marked as subvention to determine if they should simply be voided in CIS or voided and resubmitted. The research and cleanup process should be completed by 01/31/2004.

User Access Request Forms

The Office of Program Support Services must authorize all requests for access to CIS, Office of Human Rights, Office of Grievance and Appeals, and PMMIS (AHCCCS) databases. In order to obtain access to any of these databases, please fax a copy of the appropriate User Access Request Form and User Affirmation Statement to Stacy Mobbs at (602) 364-4736. For questions, please contact Stacy Mobbs by telephone at (602) 364-4708 or by e-mail at smobbs@hs.state.az.us.

AHCCCS Encounters Error Codes

H280 – Encounter Not Eligible to Adjust

Encounters are pending because the adjustment submitted does not match the original. Encounters submitted for adjustment must match the provider and client ID numbers from the original encounter. Encounters pending for this reason must be ***voided*** instead of corrected.

R295 – Medicare Reported But Not Indicated

The Medicare (MDC) Approve and MDC Deduct fields must be blank if the recipient does not have Medicare, otherwise the encounter will pend. If the recipient has Medicare but Medicare denies the service, report zero (0) in the MDC Approve, MDC Deduct, and MDC Paid fields. Please refer to AHCCCS PMMIS system, RP150 Inquire Medicare Coverage screen. This allows Contractors to review the Medicare information that AHCCCS has on file. If you need further assistance, please contact your technical assistant.

Z720–Exact Duplicate Found

Encounters are pending because at least one claim was found in the system that matches the pending claim. These claims need to be researched by the RBHA's to determine the cause for the exact duplicate. Multiple units of service for the same client on the same day need to be combined into one encounter.

Example: A client receives Self-help/Peer service (peer support), per 15 minutes twice in one day; H0038 needs to be billed as one claim with two units instead of two claims for one unit each.

Z575 – Date of Service Already Billed on an Outpatient from Different Health Plan

Encounters are pending because the admit hour on an inpatient encounter is before discharge hour on a competing encounter and cannot be overridden. Generally, this is a result of two encounters for one service submitted by two plans. Contact the other plan to determine if there are overlaps in dates of service; and who should have paid for the service or how much of the service. If you need further assistance, contact your technical assistant.

These four errors account for 81.57% of the pended encounters at AHCCCS.

Important Definitions for Corporate Compliance

The term ***health plan*** refers to a plan, program or organization that provides health benefits, whether directly or through insurance, reimbursement or otherwise. Entities may be recognized as "health plans" if they meet the basic criterion of "providing health benefits." Health plans include, but are not limited to:

- A policy of health insurance
- A contract of a service benefit organization
- A membership agreement with a health maintenance organization or other prepaid health plan
- A plan, program, or agreement established, maintained, or made available by an employer or group of employers; a practitioner, provider, or supplier group; a third-party administrator; an integrated health care delivery system; an employee welfare association; a public service group or organization; or a professional association
- An insurance company, insurance service, or insurance organization that is licensed to engage in the business of selling health care insurance in a State, and which is subject to State law which regulates health insurance

Health plans may include those plans funded by Federal and State governments, including:

- Medicare
- Medicaid
- The U.S. Department of Defense
- The U.S. Department of Veterans Affairs
- The Bureau of Indian Affairs programs

Federal health care program means any plan or program providing healthcare benefits, whether directly through insurance or otherwise, that is funded directly, in whole or part, by the United States Government (other than the Federal Employees Health Benefits Program), or any State health care program as defined in this section beneficiaries within a defined service area (42 CFR § 1001.2).

Material violations are defined as a substantial overpayment or a matter that a reasonable person would consider a potential violation of criminal, civil, or administrative laws applicable to any Federal health care program for which penalties or exclusion may be authorized. A material deficiency may be the result of an isolated event or a series of occurrences.

Who's Who in the Division of Behavioral Health…..

Who are, and what does the Bureau of Children's Services do?

The mission of the Bureau of Children's Services is to support and monitor a statewide system for the delivery of comprehensive community-based behavioral health services for all of Arizona's children and adolescents.

In 1988, Arizona enacted landmark legislation mandating the development and delivery of a comprehensive continuum of coordinated behavioral health care for children. Previously these services had been provided by different agencies according to individual mandates addressing specific populations of children. ARS 36-3431, et. seq. requires interdepartmental collaboration for a single system to address the behavioral health needs of all Arizona children. DBHS was designated the lead agency for the development of this children's system.

Office of Program Support Staff

If you need assistance, please contact your assigned Technical Assistant at:

Stacy Mobbs	Gila River Navajo Nation Pascua Yaqui	(602) 364-4708
Michael Carter	NARBHA PGBHA	(602) 364-4710
Eunice Argusta	CPSA-3 CPSA-5	(602) 364-4711
Javier Higuera	Excel Value Options	(602) 364-4712

Billing Questions…

CPT/HCPCS

Physicians' Current Procedural Terminology (CPT) and HCFA Common Procedure Coding System (HCPCS) are nationally recognized service codes. For more information regarding these codes see:

- The *Physicians' Current Procedural Terminology (CPT) Manual*, which contains a systematic listing and coding of procedures and services, such as surgical, diagnostic, or therapeutic procedures.
- The *HCFA Common Procedure Coding System (HCPCS) Manual*, which is a systematic listing and coding for reporting the provision of supplies, materials, injections and certain services and procedures.

National Drug Codes (NDC)

These nationally recognized drug codes are used to bill for prescription drugs. Information regarding these pharmacy-related codes can be found in the *First Data Bank Blue Book.*

UB92 Revenue Codes

These nationally recognized revenue codes are used to bill for all inpatient and certain residential treatment services. Information regarding these codes can be found in the *UB92 Manual.*

When can a parent, spouse, and/or legal guardian of an enrolled person provide personal assistance?

Pursuant to Title XIX requirements, a parent and/or legal guardian *may not be reimbursed* for the provision of personal assistance to a child under the age of 21 years. If the parent is the legal guardian of an adult, they may provide personal assistance. A spouse may not be reimbursed for the provision of personal assistance.

Edit Alerts

An Edit Alert is a faxed and e-mailed notice of system enhancements or changes. The Office of Program Support strives to ensure any system enhancements or changes are communicated to all program participants in an accurate and reliable manner. Edit Alerts will be distributed when the information is first made available and again with the following monthly publication of the Encounter Tidbits.

** There are no Edit Alerts this month **